DILEY
MEDICAL GROUP

PATIENT DEMOGRAPIC INFORMATION

Please Complete This Entire Form. Thank You!

Today's Date: ____/____/____ Referred By (If Applicable): _____

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MI:	DOB (MM/DD/YYYY):
MAILING ADDRESS:	CITY:	STATE:	ZIP:
PHYSICAL ADDRESS (If different from mailing address):	CITY:	STATE:	ZIP:
HOME PHONE:	CELL PHONE:	WORK PHONE:	
E-MAIL ADDRESS:	USE E-MAIL ADDRESS FOR PATIENT PORTAL: ◻ Yes ◻ No ◻ Not Applicable	SOCIAL SECURITY #:	
GENDER: ◻ Male ◻ Female ◻ Transgender ◻ Unknown	RACE: ◻ American Indian/Alaskan Native ◻ Asian ◻ Black/African American ◻ Hispanic ◻ Native Hawaiian/Other Pacific Islander ◻ White ◻ Refuse to Report ◻ Other		
ETHNICITY: ◻ Hispanic/Latin ◻ Non-Hispanic/Latin ◻ Refuse to Report	PREFERRED LANGUAGE: ◻ English ◻ Spanish ◻ Other Language (please specify):		
MARITAL STATUS: ◻ Single ◻ Married ◻ Separated ◻ Divorced ◻ Widowed			
DO YOU HAVE A CAREGIVER: ◻ Yes ◻ No	IF YES, NAME OF CAREGIVER:	IF YES, MAY WE RELEASE PROTECTED HEALTH INFORMATION TO YOUR CAREGIVER: ◻ Yes ◻ No	

EMERGENCY CONTACT

LAST NAME:	FIRST NAME:	RELATIONSHIP (Please specify):
HOME PHONE: ( )	CELL PHONE: ( )	MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL: ◻ Yes ◻ No

EMPLOYER INFORMATION

EMPLOYER NAME:	EMPLOYER PHONE NUMBER: ( )
EMPLOYMENT STATUS ◻ Employed ◻ Full Time ◻ Part Time ◻ Retired ◻ Self Employed ◻ Unemployed ◻ Active Military ◻ Student	

INSURANCE INFORMATION

(Please present all current insurance cards to the Front Desk)

I HAVE INSURANCE: ◻ Yes ◻ No (Self Pay)			
PRIMARY INSURANCE:		SECONDARY INSURANCE:	
SUBSCRIBER:	RELATION:	SUBSCRIBER:	RELATION:
GENDER: ◻ Male ◻ Female ◻ Transgender ◻ Unknown		GENDER: ◻ Male ◻ Female ◻ Transgender ◻ Unknown	
DATE OF BIRTH (mm/dd/yyyy):	SOCIAL SECURITY #:	DATE OF BIRTH (mm/dd/yyyy):	SOCIAL SECURITY #:

CONFIDENTIAL COMMUNICATION

(I hereby request to receive confidential communications from DMG in the following manner)

TELECOMMUNICATIONS –Please leave messages regarding my protected health information as follows (Check All That Apply):	POSTAL COMMUNICATIONS –Please mail my protected health information to me at (Select Only One):
◻ Home Phone of Record ◻ Brief ◻ Extended ◻ Cell Phone of Record ◻ Brief ◻ Extended ◻ Work Phone of Record ◻ Brief ◻ Extended	◻ Mailing Address of Record ◻ Street Address of Record ◻ Other: _____ Street Address City State Zip

ADVANCE DIRECTIVES

DO YOU HAVE A LIVING WILL?	◻ No	◻ Yes	(If yes, please provide a copy to the Front Desk)
DO YOU HAVE A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?	◻ No	◻ Yes	(If yes, please provide a copy to the Front Desk)
DO YOU HAVE A DO NOT RESCUSITATE?	◻ No	◻ Yes	(If yes, please provide a copy to the Front Desk)

Diley Medical Group
New Patient History

Date:
Name: _____ _____ ____ Date of Birth: _____
LAST *FIRST* *MI* *MM/DD/CCYY*

Current Physicians/Specialists: _____
Pharmacy: _____

Current Medications- please include your directions

1) _____ 7) _____
2) _____ 8) _____
3) _____ 9) _____
4) _____ 10) _____
5) _____ 11) _____
6) _____ 12) _____

Allergies to medication, x-ray dyes, or food: _____

Past Medical History: check all that apply

☐ Alzheimer's/Dementia	☐ Hypertension
☐ COPD	☐ Hypothyroidism
☐ Cancer	☐ Insomnia
☐ Coronary Artery Disease	☐ Obstructive Sleep Apnea
☐ Depression	☐ Stroke/TIA
☐ Diabetes	☐ Seizures
☐ Headache/Migraines	☐ Other _____
☐ Hyperlipidemia	

Past Surgical History: _____
_____
_____
_____

Gynecological History: if menopausal, age at menopause: _____
Last pap smear: _____ Last mammogram: _____

Family History: _____

Last Colonoscopy: _____ Last Eye Exam: _____ Most recent labwork: _____

Flu Vaccine: _____ Pneumonia Vaccine: _____

Social History: Married/Widowed/Divorced/Single Live alone or with others Live in single level or multi-level home Occupation: _____ Education: _____ Smoking Status: Never/Former/Current _____ packs/days for _____ years Alcohol Intake: None/Occastional/Moderate/Heavy _____drinks/week Illicit Drugs: _____ Caffeine Intake: None/Occasional/Moderate/Heavy Chewing Tobacco: None/1 day/2-4 day/5+ day	Exercise level: None/Occasional/Moderate/Heavy Diet: Regular/Vegetarian/Vegan/Gluten free/Cardiac/Diabetic/Other: Advance Directive: Yes/No Difficulties with any of the following: Caring for self Transportation Hearing Seeing Concentrating, remembering or making decisions Walking Climbing stairs Dressing Bathing Doing errands alone

HIPAA (Health Insurance Portability Accountability Act) CONSENT

Diley Medical Group consent for disclosure of your Protected Health Information

Diley Medical Group will obtain and maintain protected health information (PHI) pertaining to you, a patient of our practice. Please be advised that we will use and disclose your PHI as necessary to treat you, receive payment for services and facilities provided to you, and for administration of health care operations. Our practice's ability to use and disclose a patient's PHI is more fully discussed in our NOTICE TO PATIENTS regarding Protected Health Information, which can be provided to you at your request and is posted in our waiting room. Prior to signing this consent, you have the right to review the NOTICE to PATIENTS regarding Protected Health Information and we will provide you with a copy of such Notice or make copies of such Notice available to you if it is materially amended in the future.

As a patient of Diley Medical Group you have the right to restrict our practice's use or disclosure of your PHI for carrying out treatment, payment, or health care operations; however, Diley Medical Group does not have to agree with such restrictions. Nevertheless, if we agree to your restrictions, we agree to be bound by such restrictions.

Unless Diley Medical Group has relied and acted upon your consent to use or disclose your PHI, you have the right to revoke this consent by providing our practice with a written revocation of consent.

If you should have questions regarding such consent, please contact the Privacy Officer of Diley Medical Group.

In accordance with Federal regulation and Diley Medical Group's "Privacy Policy" and "Privacy Procedures," the following has been implemented. At no time shall any person receive Protected Health Information (PHI) that pertains to any individual unless prior authorization has been completed.

I have read and understand this document and authorize the following person(s) to receive PHI in my absence to include, but not limited to: prescriptions, laboratory and radiology requests/ results, and medication samples. Please print names & relationship to patient.

1. Name_____ Phone number_____
   Relationship to patient _____
2. Name_____ Phone number_____
   Relationship to patient _____
3. Name_____ Phone number_____
   Relationship to patient _____
4. Name_____ Phone number_____
   Relationship to patient _____
5. Name_____ Phone number_____
   Relationship to patient _____

Print Patient's Name: _____ Date of Birth: _____

Patient Signature: _____ Effective Date: _____

DILEY
MEDICAL GROUP

Patient Registration and Policy Agreements

Receipt of Notice of Privacy Practices: I have been offered the HIPAA Notice of Privacy Practices at DMG which outlines my privacy rights and how DMG may use and disclose Protected Health Information about me.

□ **Yes** □ **No** □ **Offered but Decline** **Initials:** _____

Photograph for Patient Identification: I give my consent to the use of my photograph for identification on my electronic health record.

□ **Accept** □ **Decline** **Initials:** _____

Telephone Contacts, Monitoring and Recording: this does not include calls related to appointments, billing or health-related information I hereby consent and agree that: (1) any calls with DMG may be monitored and/or recorded and that DMG (or anyone acting on DMG's behalf) may contact me, from time to time, regarding my account (including for collections purposes or related to insurance coverage) or regarding my most recent visit with my provider; (2) any and all of DMG's contacts with me may be made via text message or with an automated dialing device; (3) DMG may contact me at any telephone number I provide to them, whether a residential, business number, or mobile number; (4) DMG may e-mail newsletters informing me of new services or suggested health screenings; and (5) I have an established business relationship with DMG and DMG may contact me in any of the ways described above. I understand that, if I accept now, I may opt-out at any time by notifying the DMG.

□ **Accept** □ **Decline** **Initials:** _____

Health Information Exchange (HIE): DMG participates in one or more Health Information Exchanges that share medical information to facilitate improved care through a comprehensive health record. This information is secure and only available to those providers involved in your care delivery. I agree that my DMG provider may allow access to my health information through the Health Information Exchange for treatment or other health care operations. This is a voluntary agreement. I understand that I may opt-out at any time by notifying DMG.

All DMG patients are automatically enrolled in the HIE unless the Opt Out box is checked and initialed. □ Opt Out Initials: ___

E-Prescribing: E-Prescribing is a way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also may provide the health care provider information about which drugs are covered by your drug benefit plan and may also provide the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.
The medication history information would include medications prescribed by your health care provider at Diley Medial Group as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, genetic diseases, and HIV/AIDS. ***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.***
All DMG patients are automatically enrolled in the HIE unless the Opt Out box is checked and initialed. □ Opt Out Initials: ___

Medication policy: The medication given to you should be taken as prescribed by your doctor. The medications may not be used for any purpose other than that for which they are prescribed. These medications may not be given nor sold to another individual. Keep all narcotic medications locked up. If a medication is stolen or lost it will not be able to be replaced until it is due for a refill. Police reports of theft are not accepted. **Breaking these rules may be cause to terminate your treatment and discharge you from our practice.**

1. You will be given enough medication to last a specific length of time. Please read the directions each time you get a prescription filled. You must take your medication according to the directions and no medications will be refilled early. You must keep track of your medications to ensure that you do not run out before the specified time. **It is your responsibility to schedule follow-up appointments far enough in advance so you do not run out of medication.**

2. Requests for medication will only be considered between **9:00am and 4:00pm Monday through Thursday and 9:00am to 12:00pm on Friday.** In addition, no medication requests will be processed after office hours, on weekends, or on holidays.

3. Requests for medication should be called directly to our office or through the Patient Portal website. **Please allow 48 hours to process your request.** We expect you to be seen in the office every **3 months** or as directed for **routine medications.** For any **narcotic or ADHD medications,** you are required to be seen **every 30-60** days as directed by the provider. Your physician may not fill this medication until you are seen in the office.

4. **We do not prescribe for chronic narcotic use.** If there is a need for pain management, we will refer you to a pain specialist.

Confidential Communications: I understand DMG will notify me if DMG is unable to comply with my request for Confidential Communications.

Release of Protected Health Information in Emergency Situation: I understand that my protected health information may be released as my physician determines appropriate in an emergency situation.

Appointment cancellations/no-shows: I understand keeping scheduled appointments is an important part of your health care. It allows your doctor or dentist to talk about your illnesses and what you can do to stay healthy. When you miss an appointment, you also miss out on the opportunity to improve your health. In addition, it takes the appointment away from another patient who may need it. I understand that if I do not show up for an appointment or call to cancel my appointment with more than 24hours notice three (3) or more times in a twelve (12) month period, I may be terminated as a patient.

Late policy: We understand that delays can happen, however, we must try to keep the other patients and doctors on time. If you are running late, please notify the office. If a patient is 15 minutes past their scheduled time, we may have to reschedule your appointment. If you are still able to be seen the same day, you may have an increased wait time.

Financial policy: I understand that payment of my bill is considered part of my treatment. Fees are due and payable when services are rendered. DMG accepts cash, check, and credit cards. For checks returned unpaid by my bank, a $25.00 fee will be assessed.

Bad debt policy: I understand that I will receive monthly statements to the address I provide to DMG, and it is my responsibility to notify DMG of any address changes. I will be placed in to bad debt after 4 months of no payments and will no longer be able to be seen in office until my account is current. After an additional 2 months of no payments, I understand that I could be terminated from the practice.

Insurance Assignment and Acknowledgement: I understand my insurance carrier can choose to assign benefits to DMG or my Insurance carrier may make a payment directly to me. I understand and certify I am financially responsible for all health care service charges that are paid to me directly or by my insurance carrier as well as any applicable co-payments, co-insurance, deductibles and/or charge for non-covered service provided to me or to any of my dependents. I am also responsible for providing up-to-date and accurate insurance information. It is my responsibility to know my own insurance benefits, including whether DMG is a contracted provider with my insurance company; my covered benefits and any exclusions in my insurance policy; and any pre-authorization requirements of my insurance company.

Medicare and Medicaid: I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

I authorize any holder of medical or other information about me to release to the Social Security Administration, Medicare, Medicaid, and/or its intermediaries/carriers, as well as my commercial insurance carriers any and all information required for claim consideration and payment. I certify that I will pay to DMG any co-payments, co-insurance, deductibles or non-covered services. I will immediately pay to DMG any payments that I receive from my insurance carrier for services provided to me and/or my dependents. I will also be responsible for any amounts not paid by my insurance for my failure to provide the appropriate insurance information for billing.

By signing below, I am acknowledging that I have read and understand all the above statements.

Patient Printed Name	Patient Signature	Date Signed
Legal Guardian Printed Name (if applicable)*	Legal Guardian Signature (if applicable)*	Date Signed

***PLEASE PROVIDE A COPY OF LEGAL GUARDIANSHIP COURT PAPERS FOR THE PATIENT'S RECORD**